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| **NAME:** | | | **SIMS:** |
| **PARENT/GUARDIAN NAME:** | | | **PHONE:** |
| **ADDRESS:** | | | **WK PHONE:** |
| **Email:** | | |  |
| **SCHOOL DISTRICT:** | | **SCHOOL:** | |
| **DOB:** | **AGE:** | | **GRADE:** |
| EC PROGRAM: |  | | |
| **GENDER:** \_\_\_\_\_\_\_\_\_\_\_ | **RACE:** \_\_\_\_\_\_\_\_\_\_\_ | | |
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| Name of Referring Person:  Signature: | Date of referral: |

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| List the strategies/interventions that have been implemented in the classroom prior to this referral (may attach documentation): |
| Is the child on medication?  No  Yes  Medical Concerns/Diagnoses(ex. Has the child been diagnosed with a medical condition, such as vision or hearing loss?): |

**Please check those items below that further describe your area(s) of concern:**

**COGNITIVE SKILLS**

Follows verbal and gestural commands  Retells/Repeats Stories, Songs

Understands cause/effect  Identifies Body Parts  Identifies Shapes

Identifies Categories (Object, Use)  Remembers Directions  Identifies Colors

**BASIC READING SKILLS**

Rhyming  Blends Sounds to Make Words  Enjoys being read to

Identifies Letters of the Alphabet  Identifies Sounds in Words  Demonstrates use of books

Letter-Sound Correspondence  Syllabication

**BEGINNING MATH SKILLS**

Rote Counting  One to One Correspondence  Understands Patterns

Quantitative Concepts (size, shape, length)  Understands More/Less

**FINE MOTOR SKILLS**

Use of eating utensils  Feeds Self  Pencil Grip

Formation of shapes/letters, etc.  Cutting skills

**GROSS MOTOR SKILLS**

Walking, running Balance  Ball Skills

Using playground equipment Sitting in chair/circle time

**ADAPTIVE SKILLS**

Toilet training  Feeding  Bathing/Washing Hands

Dressing  Understands dangerous situations/shows caution

Sleep Routines  Food sensitivity  Personal Information

**SOCIAL SKILLS**

Appropriate behavior in public  Greets Others  Engages in Role Play

Allows others to participate in play  Understands & Recognizes Feelings  Assists others

**EXPRESSIVE COMMUNICATION**

Pragmatics (Social language/conversation)  Provides information

Vocabulary/Concepts (# of Words used)  Names Object & People

Participates in Conversation (turn taking)  Sentence Length

Uses Pronouns  Retells a story

Reasoning/Problem Solving (gives answers to problems) Grammar (syntax;incorrect pronouns)

**RECEPTIVE COMMUNICATION**

Auditory Attention Span (blocks out competing auditory information)  Sequences of Events (nonverbally)  Follows Directions Promptly  Understands Directions

Auditory Discrimination (discriminates two auditory words/sounds)  Answers “Wh” questions

Auditory Memory (remembers songs/rhymes)  Understands Negatives

**SPEECH**

Articulation (correct production of sounds)

Fluency (stutters/repeats words or syllables, hesitates, prolongs words)

**BEHAVIOR/EMOTIONAL (Extreme or Excessive)**

Independent Activity  Group Activity  Peer Relationships

Attention Span  Overactive  Home Relationships

Passive/Shy  Verbally Aggressive  Unresponsive

Withdrawn  Disruptive  Physically Aggressive

Mood Swings  Motivation  Other (specify)

Non-Compliant  Teacher Relationships

MUST comment on areas checked and include frequency and duration:

**HEALTH**

Hearing (Specify Concerns)

Vision (Specify Concerns)

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| **(District Use Only)**  Date of conference held with person making the referral:        Method  Teacher Information:  Review of student record (i.e. attach current grades, attendance record, enrollment gaps, various school enrollments, retention information, State and District-wide Assessment data, etc.): |
| Based upon a review of all referral information, potential areas of disability to evaluate are:  0500-D/B  0505 -ED  0510-CD  0515-HL  0525-SLD  0530-MD  0535-OI  0540 –VL  0545 –D  0550-S/L  0555-OHI  0560-A  0565-TBI  0570-DD  Refer to the South Dakota Eligibility Guide for testing areas required to determine eligibility. |
| Parent Contacted: (Date)  Parent information:  If this was a parent referral, and the district determines evaluation is **not** necessary, Prior Notice was sent to parents: (Date) |